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Amendment No. 1 to HB3340

Hargrove
Signature of Sponsor

AMEND Senate Bill No. 3424* House Bill No. 3340

by deleting all language following the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5 is amended by adding Sections 2 through 12 below as a new, appropriately designated part thereto.

SECTION 2. It is the intent of the general assembly to provide access to health insurance coverage to Tennesseans with incomes at or below two hundred percent (200%) of the federal poverty guidelines who are unable to qualify for adequate health insurance. It is specifically the intent of the general assembly to establish a mechanism that offers adequate levels of health insurance coverage to residents of Tennessee who are otherwise uninsurable or who are underinsured.

SECTION 3. As used in this part, unless the context otherwise requires:

(1) "Bureau" means the bureau of TennCare;

(2) "Church plan" has the meaning given such term under ERISA (29 U.S.C. §1002(33));

(3) "COBRA continuation coverage" refers to continuation of coverage offered pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. §§ 300bb-1 *et seq.*);

(4) "Commissioner" means the commissioner of finance and administration;

(5) "Creditable coverage" means:

(A) With respect to an individual, coverage of the individual provided under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§1395 *et seq.*);

(iv) Medicaid, other than coverage consisting solely of benefits under §1928 of the Social Security Act (42 U.S.C. §1396s);

(v) The civilian health and medical program of the uniformed services (10 U.S.C. §1071 *et seq.*);

(vi) A medical care program of the indian health service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under the federal employees health benefits program (5 U.S.C. §§8901 *et seq.*);

(ix) A public health plan as defined in federal regulations; or

(x) A health benefit plan under the Peace Corps Act (22 U.S.C. §2504(e)).

(B) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this part, if, after such period and before the enrollment date, the individual experiences a significant break in coverage;

(6) "Department" means the department of finance and administration;

(7) "Dependent" means a spouse or unmarried child under nineteen (19) years of age, or a child who is a student under twenty-three (23) years of age and who is financially dependent upon the parent;

(8) "ERISA" means the Employee Retirement Income Security Act of 1974 (29 U.S.C. §§1001 *et seq.*);

(9) "Federally defined eligible individual" means an individual:

(A) For whom, as of the date on which the individual seeks coverage under this part, the aggregate of the periods of creditable coverage is eighteen (18) or more months;

(B) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

(C) Who is not eligible for coverage under a group health plan, medicare, medicaid, or any successor program, and who does not have other health insurance coverage;

(D) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) Who, if offered the option of continuation of coverage under a COBRA continuation coverage provision or under a similar state program, elected such coverage; and

(F) Who has exhausted the continuation coverage described in subdivision (E);

(10) "Governmental plan" has the meaning given such term under ERISA (29 U.S.C. § 1002(32));

(11) "Group health plan" means an employee welfare benefit plan as defined in ERISA (29 U.S.C. §1002(1)) to the extent that the plan provides medical care, as defined in subsection (20), and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

(12) "Health insurance coverage" means:

(A) Any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(B) "Health insurance coverage" shall not include one or more, or any combination of, the following:

(i) Coverage only for accident, or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; and

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §§201 *et seq*.), under which benefits for medical care are secondary or incidental to other insurance benefits.

(C) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §§201 *et seq*.).

(D) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to

whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under §1882(g)(1) of the Social Security Act (42 U.S.C. §1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under the civilian health and medical program of the uniformed services (10 U.S.C. §071 *et seq.*); or

(iii) Similar supplemental coverage provided to coverage under a group health plan;

(13) "Health maintenance organization" means an organization as defined in §56-32-202;

(14) "Hospital" means a licensed public or private institution as defined by §68-11-201;

(15) "Insurance arrangement" means, to the extent permitted by ERISA, any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer;

(16) "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this part, insurer includes but is not limited to an insurance company; a health maintenance organization; a preferred provider organization, a hospital and medical service corporation; a surplus lines insurer; an insurer providing stop-loss or excess loss insurance to a group health plan; a reinsurer reinsuring health

insurance in this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(17) "Medicaid" means the federal- and state-financed, state-run program of medical assistance established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 *et seq.*) and any waivers thereof;

(18) "Medical care" means amounts paid for:

(A) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) Transportation primarily for and essential to medical care; and

(C) Insurance covering medical care referred to in subdivisions (A) and (B);

(19) "Medicare" means coverage under Parts A or B of Title XVIII of the Social Security Act, (42 U.S.C. §§1395 *et seq*., as amended);

(20) "Program" means the health insurance coverage program created pursuant to this part;

(21) "Preferred provider organization" means any person, partnership, association, corporation or entity which contracts with a hospital, hospitals or other health care providers for the provision of health care services by the hospital, hospitals or health care providers at a discounted rate, a per diem charge or any other pricing arrangement which is less than the charge made for medical services without such a contract arrangement;

(22) "Resident" means an individual who is legally domiciled in Tennessee;

(23) "Significant break in coverage" means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage; and

(24) "Third party administrator" means any entity that, on behalf of an insurer or insurance arrangement, provides health insurance coverage to individuals in this state,

receives or collects charges, contributions or premiums for or adjudicates, processes or settles claims in connection with any type of health benefit provided in or as an alternative to health insurance coverage.

SECTION 4. The bureau is authorized to establish, administer, and monitor a program to provide health care coverage to uninsurable Tennesseans with incomes at or below two hundred percent (200%) of the federal poverty guidelines. The program shall not constitute an entitlement to coverage for eligible individuals, and the availability of program benefits are subject to appropriations.

SECTION 5. The commissioner, on or before October 1, 2006, shall determine the initial enrollment limit of the program based on the availability of any state and federal funds appropriated for the program. On November 1, 2006, an initial two (2) month enrollment period for the program shall be instituted, with enrollment for the program to end when the enrollment limit has been reached or, if it the enrollment limit is not reached prior to December 31, 2006, on December 31, 2006. A subsequent enrollment period is to be opened each subsequent November under the same restrictions, provided that the commissioner determines that enrollment capacity for the program is available. Initial coverage for the program shall become effective January 1, 2007.

SECTION 6. Beginning no later than October 1, 2008, the commissioner shall make an annual report to the governor, the general assembly and the comptroller of the treasury, to be submitted by October 1st of each year. The report shall be in a form approved by the governor and shall summarize the activities of the program in the preceding calendar year, including enrollment, the expense of administration, and the fiscal health of the program. The report shall also include an evaluation of the ability of low income uninsurable individuals to participate in the program.

SECTION 7. The commissioner may, by rule, establish such powers and duties of the program and may adopt such rules as are necessary and proper to implement this part, including but not limited to any rules or regulations necessary to comply with or implement the provisions of any federal requirement, federal waiver or state plan governing the program. Such

rules shall be promulgated as public necessity rules pursuant to §4-5-209. All rules and regulations governing the program shall be promulgated in accordance with the Uniform Administrative Procedures Act compiled in title 4, chapter 5. The rules may include, as necessary, but need not be limited to:

(1) The application, enrollment and disenrollment processes for the program;

(2) The benefit package to be provided through the program;

(3) Provisions for participant cost sharing, if any, including, at the bureau's discretion:

(A) The establishment of enrollment fees, premiums, deductibles and co-payments; and

(B) The process for setting the amounts of enrollment fees, premiums, deductibles, and co-payments, taking into account a participant's family income;

(4) The type of professionals or other provider entities who may deliver services or direct the delivery of services and the qualifications required of those professionals or entities; and

(5) Provisions regarding the sharing of health information under this plan.

In adopting rules, the commissioner shall consider the federal requirements on which the receipt of Title XXI funding is contingent and shall not establish any program criteria or requirements that will disqualify the program for such funding. Rules adopted by the commissioner must, when appropriate, take into account the availability of appropriated funds.

SECTION 8.

(a) A federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for program coverage.

(b) The commissioner may establish eligibility criteria to provide program coverage for additional individuals.

(c) In the first twelve (12) months of the program's operation, such criteria shall include, with respect to individuals who are not federally defined eligible individuals:

(A) A requirement that an individual be a resident of Tennessee for at least six (6) months;

(B) A requirement that an individual not have had health insurance coverage in the previous six (6) months;

(C) A requirement that an individual not have access to health insurance coverage, including coverage under any other Tennessee medicaid program, at the time of application to the program;

(D) A requirement that an individual exhaust any option of continuation coverage under a group or individual health insurance plan, including COBRA continuation coverage;

(E) A requirement that an individual have a combined family income no greater than two hundred percent (200%) of the federal poverty guidelines;

(F) A requirement that an individual is a United States citizen or qualified alien as defined in 8 U.S.C. 1641(b); and

(G) A requirement that the person not have coverage pursuant to §56-7-2809.

The commissioner shall establish procedures to verify that the criteria in subdivisions (A) through (G) have been met.

(d)

(1) In the first twelve (12) months of the program's operation, the program shall not offer coverage to dependents or other family members of a person who is eligible for coverage, unless such dependent or family member independently meets the eligibility criteria established by the commissioner.

(2) At the end of the first year of the program's operation or anytime thereafter the commissioner may assess the implementation and impact of the eligibility criteria established in this section and modify such criteria in the commissioner's discretion.

(3) The commissioner may establish additional eligibility criteria to provide program coverage for individuals who are not federally defined eligible individuals. Such criteria may include:

(A) A list of medical or health conditions for which a person shall be eligible for program coverage without applying for health insurance;

(B) A requirement that an individual be uninsured for a specified period of time prior to obtaining program coverage;

(C) Minimum residency requirements;

(D) Citizenship requirements; or

(E) Any other eligibility criteria that the commissioner deems appropriate that are not in conflict with other provisions of this part.

(e) The commissioner may establish limits on the number of individuals covered by the program or the duration of coverage, based on available funding.

(f) A person shall not be eligible for coverage through the program if:

(1) The person has or obtains health insurance coverage substantially similar to or more comprehensive than that provided by the program, or would be eligible to have coverage if the person elected to obtain it, except that:

(A) A person may maintain other coverage, including COBRA continuation coverage, for the period of time the person is satisfying any preexisting coverage waiting period under the program; and

(B) A person may maintain program coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the program coverage;

(2) The person is determined to be eligible for health benefits under Medicaid;

(3) The person has previously terminated coverage in the program within twelve (12) months of the date that application is made to the program, except

that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual;

(4) The program has paid out one million dollars ($1,000,000) in benefits on behalf of the person;

(5) The person is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual; or

(6) The person has had prior coverage with the program terminated for fraud.

The commissioner may establish additional criteria that shall disqualify individuals for program coverage, provided that such criteria do not apply to federally defined eligible individuals.

(g) It shall constitute an unfair practice in the business of insurance for the purposes of §56-8-104 and §56-6-155 for an insurer, insurance producer or third-party administrator to refer an individual to the program, or arrange for an individual to apply to the program, for the purpose of separating that individual from group health insurance coverage. The commissioner has the authority and responsibility to adopt policies and procedures that effectively implement this provision.

SECTION 9.

(a) The bureau may administer the program directly or contract with insurance companies, managed care plans or other entities to provide services to enrollees. Payments for services to such contracted entities may require the contractor to assume full or partial risk for the cost of services provided under the contract. The bureau may also contract directly with health care providers to provide services to enrollees and establish appropriate rates of payments for such services.

(b) The bureau may enter into contracts or interagency agreements with an outside entity or other state agency to assist in the administration of the program, including performing eligibility determinations and appeals.

SECTION 10.

(a) The bureau may enter into contracts with one or more health insurance carriers or third party administrators selected through a competitive procurement process to provide a plan of health benefits coverage to eligible individuals. In soliciting proposals to provide such coverage, the bureau may:

(1) Specify rates to be paid by the program to the contractor;

(2) Specify minimum requirements with respect to the health benefits to be covered by the plan, which shall prioritize preventative health services. The bureau shall consider requiring the plan to cover generic prescription drugs and routine physician visits with only limited cost sharing. The bureau may permit limitations on the amount of such services covered by the plan, and may permit increased cost sharing at higher utilization levels. The bureau shall not permit a plan to subject such services to a large global deductible;

(3) Solicit proposals with respect to specific benefits to be covered by the plan, including any limits on such benefits, provided that the bureau encourages as broad a benefit package as possible for the rates provided, with benefit limits or higher cost-sharing for appropriate services (such as non-preventative services) preferred over exclusions as a mechanism for controlling costs;

(4) Provide other incentives for the development of benefit packages emphasizing preventative and primary care coverage;

(5) Specify requirements or solicit proposals with respect to plan coverage of dependents of eligible individuals (including separate rates for dependent coverage or a requirement or proposal that no dependent coverage be offered);

(6) Specify requirements or solicit proposals with respect to plan coverage of maternity services (including separate rates for such coverage);

(7) Specify requirements or solicit proposals with respect to plan coverage or exclusions of pre-existing conditions; provided that no pre-existing

condition provision subjects an enrollee to an exclusion of longer than twelve (12) months;

(8) Specify requirements or solicit proposals with respect to enrollee cost-sharing, including cost-sharing based on a sliding scale in accordance with income as appropriate;

(9) Specify requirements or solicit proposals with respect to provider networks, consistent with the prioritization of primary care services. Where geographically appropriate, the bureau should encourage selective contracting with high performance provider networks meeting specified quality, cost and patient satisfaction criteria, and should encourage pay-for-performance provider rate structures designed to reward quality of care and cost-effective medicine, where appropriate;

(10) Specify requirements or solicit proposals with respect to quality assurance, quality improvement, disease prevention, disease or case management, cost-containment, provider reimbursement mechanisms, the use of health information technology, wellness programs, incentives for healthy living and any other programmatic innovations or requirements. The bureau should encourage plans to promote enrollee wellness and personal responsibility (such as mandatory waiting periods for enrollees who have previously dropped coverage) and to establish “equity” programs in which enrollees can earn reduced cost-sharing or increased benefits through appropriate behavior (such as extended participation in the plan or participation in disease management or other designated programs offered by the plan);

(11) Specify requirements or solicit proposals with respect to application and enrollment processes;

(12) Specify requirements or solicit proposals with respect to procedures for the plan to collect premium contributions required pursuant to §56-7-2914;

(13) Specify requirements or solicit proposals with respect to continuing coverage for enrollees who leave the employment of a contributing employer;

(14) Specify any applicable marketing guidelines, requirements or restrictions, including the use of the existing commercial brokerage network or other more direct distribution mechanisms where appropriate;

(15) Specify any applicable reporting requirements for contractors; and

(16) Include any other specifications or incentives as the bureau deems appropriate.

(b) Notwithstanding the requirements of §12-4-109, the bureau may:

(1) Consult with experts from outside the bureau and outside of state government in evaluating proposals to provide coverage under the program; and

(2) Consider the factors specified in its solicitation of proposals in awarding contracts.

(c) The bureau shall seek to offer at least two (2) plans to eligible individuals, and shall enter into contracts with one or more contractors to provide such plans. The contract shall set forth the bureau's agreements with such contractor with respect to the items contained in subsections (a)(1) through (a)(16), to the extent applicable, and any other necessary terms and conditions.

(d) Contractors shall be permitted to design the health benefits coverage offered through such plans consistent with the requirements of this part and with any additional requirements established by the bureau.

(e) Contractors may subcontract for the provision of medical, administrative or other services in connection with the plan.

(f) The bureau shall compensate contractors as provided in the contract. The bureau may offer incentives including a bonus payment to the contractors that meet enrollment criteria specified by the bureau, or for meeting other performance criteria specified by the bureau.

SECTION 11.

(a) The program shall offer at least one (1) coverage option to each eligible person who is not covered by Medicare which shall be modeled after one of the healthcare options offered to state employees pursuant to §8-27-201. The commissioner may adopt other coverage options as appropriate.

(b) The commissioner shall establish:

(1) The coverage to be provided by each option;

(2) The applicable schedule of benefits; and

(3) Any exclusions to coverage and other limitations.

In doing so, the commissioner shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in Tennessee.

(b) The coverage options offered by the program shall not be required to provide the mandated coverage or the mandated offers of coverage required pursuant to parts 23, 24, 25 or 26 of this chapter, unless required by the commissioner.

(c) Program coverage may exclude charges or expenses incurred during a period of time not to exceed twelve (12) months following the effective date of coverage as to any condition which, during a period not to exceed six (6) months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received as to such condition. Any such preexisting condition exclusion shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if the application for program coverage is made not later than sixty (60) days following such involuntary termination and, in such case, coverage in the program shall be effective from the date on which such prior

coverage was terminated. No such exclusions may be applied to a federally defined eligible individual.

(d) The program shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under program coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(e) Nothing in this part shall be construed to prohibit the program from issuing additional types of health insurance policies with different types of benefits which, in the opinion of the commissioner, may be of benefit to those individuals otherwise eligible for coverage.

SECTION 12. The office of inspector general, created pursuant to §71-5-2502, shall have the authority to investigate civil and criminal fraud and abuse or any other violation of state criminal law related to the operation of the program. The powers of the office of inspector general set forth in §§71-5-2501 through 72-5-2512 relating to the investigation of fraud and abuse in the TennCare program shall also be applicable to its investigation of fraud and abuse of this program.

SECTION 13. If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act are declared to be severable.

SECTION 14. This Act shall take effect upon becoming a law, the public welfare requiring it.